FORM IEMA.FLM-001M SUPPLEMENT A.7

Documentation of Training and Experience Required by 32 Ill. Adm. Code **335.9150** or 9160, Subpart J, for
Authorized Medical Physicist
(Attach additional pages if more than one preceptor is needed)

PART I

PROPOSED INDIVIDUALS/USES

PROPOSED AUTHORIZED MEDICAL PHYSICIST (AMP):_____

PENDING RADIOACTIVE MATERIAL LICENSE NO.: _____

INDICATE DESIRED AUTHORIZATION(S) BY CHECKING ALL THAT APPLY:	32 ILL ADM. CODE TRAINING REFERENCES
□ Y-90 Microspheres written directive required (see agency guidance)	§335.9050 or §335.9100
□ Brachytherapy (other than HDR or IVB)	§335.9100
□ I-125 Gliasite written directive required (see agency guidance)	§335.9100
□ Ophthalmic Use of Sr-90 written directive required	§335.9120
□ High Dose Rate Afterloader written directive required	§335.9140
□ Intravascular Brachytherapy written directive required	§335.9140
□ Gamma Stereotactic written directive required	§335.9140
□ Other Emerging Technologies (specify)_____ (May require additional training)	§335.2140

PART II(A)

PREVIOUSLY LICENSED METHOD*

The proposed individual is/has been named as an AMP on a Radioactive Material License for the same uses. Use the other parts of this form if the individual is not approved for all desired authorizations on the attached license.

The AMP is authorized on:

Medical Institution: _____

Address _____

RSO Name _____Phone _____ Email _____

Institution's Radioactive Material License No. _____Amendment No._____Permit No. (broad scope)_____
(Submit a copy of the radioactive material license (and broad scope permit as needed)

For previously licensed AMPs seeking additional authorizations or for those that have not been licensed within the last 7 years, proceed to Part II(C) to document classroom and work experience.

********** **OR** **********

PART II(B)

BOARD CERTIFICATION METHOD†

Specify board certification(s). Evidence (i.e., photocopy) of each certification MUST be submitted with this form. Attestation by a preceptor AMP is now required for board certified candidates as well. If the individual is not fully certified OR if the certification does not satisfy Subpart J requirements, then other parts of this form MUST be used. Check NRC's website at http://www.nrc.gov/materials/miau/med-use-toolkit/spec-board-cert.html to ensure boards are approved and certificates contain specified language.

Board _____ Specialty _____ Year _____

Board _____ Specialty _____ Year _____

I hereby attest that, under my supervision, _____ has satisfied the training requirements specified in 32 Ill. Adm. Code 335.9150(a) for the use(s) of radioactive material specified above, and has achieved a level of radiation safety knowledge sufficient to function independently as the authorized medical physicist for the specified medical use(s.) The supervised training and experience were acquired at:

Medical Institution _____

Address _____

Supervising AMP's Name _____Phone _____ Email _____

Institution's Radioactive Material License No. _____Amendment No. _____Permit No. (broad scope) _____
(Submit a copy of the radioactive material license (and broad scope permit as needed)

Supervising AMP's Signature and Date: _____

********** **OR** **********

PART II(C)

STRUCTURED TRAINING AND EXPERIENCE METHOD†

I hereby attest that, under my supervision, _____ has satisfied the training requirements specified in 32 Ill. Adm. Code 335.9150(b) for the use(s) of radioactive material specified above, and has achieved a level of radiation safety knowledge sufficient to function independently as an authorized medical physicist for the specified medical use(s.) The supervised training and experience were acquired at:

Medical Institution _____

Address: _____

Supervising AMP's Name _____Phone _____ Email _____

Institution's Radioactive Material License No. _____Amendment No._____ Permit No. (broad scope) _____
(Submit a copy of the radioactive material license (and broad scope permit as needed)

Clinical Training (1 year): Hours _____Dates _____

Work/Experience (1 year): Hours _____Dates _____

Specific Use/Device Training (as needed): Hours_____ Dates _____ Type of Use/ Device _____

Trainer (i.e., vendor or AU) _____ (Attach vendor certificate as necessary.)

Supervising AMP's Signature and Date: _____

PART III

REQUESTING LICENSEE'S CERTIFICATION[±]

As a member of management or as the radiation safety officer, I am authorized to act on behalf of the licensee. I have completed the appropriate section of this form and certify that all information contained herein, including any supplements attached hereto, is true and correct to the best of my knowledge. I hereby request the above changes to our Illinois Radioactive Material License.

Name: _____ Title: _____

Signature: _____ Date: _____

[*] Previously licensed means that individual was on an Illinois, U.S. NRC or other Agreement State license within the last seven years.

[†] Attestations must be signed by the individual **directly** supervising the training. Residency Directors or Department Heads cannot sign the preceptor statement unless they are the supervising preceptor.

[±] If the certifying individual is not known to the Agency, a due diligence request on the individuals background may be required.